

Conversations on Jesuit Higher Education

Volume 18

Article 6

9-1-2000

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Recommended Citation

Singer, Larry (2000) "Sponsorship as Living the Mission," *Conversations on Jesuit Higher Education*: Vol. 18, Article 6.
Available at: <http://epublications.marquette.edu/conversations/vol18/iss1/6>

Sponsorship as Living the Mission

LARRY SINGER



Religious communities have a rich history of health care service to the United States. From humble beginnings over 150 years ago, Catholic health care providers now constitute the single largest institutional provider of health care in the country. Catholic hospitals account for more than 16% of hospital admissions, 17% of inpatient surgical procedures, and 25 million patient encounters, in the process generating more than \$40 billion in patient revenues. Skilled nursing and assisted living facilities, along with community health programs, touch hundreds of thousands of lives daily. Many health care organizations own and operate senior care residential services, as well as oversee housing programs for the indigent. Clearly Catholic health care is “big business,” and yet the ministry has remained true to its call to service and its fundamental mission of providing physical and spiritual healing, with a special emphasis on the underserved.

A fundamental reason for this steadfastness of purpose has been the effectiveness of the relationship which exists between the religious community and its

health care ministry. Often supported by a rich history of nurturing and support, and coupled with strong accountability between community and ministry, “sponsorship” has been the mechanism used to enable the Sisters to transition from the bedside to corporate and governance positions while assuring a connection to the mission of the sponsor and the greater Church. While this mechanism has worked well, sponsorship is being called to evolve in light of two extremely dynamic environmental challenges: (1) a significant decline in

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the numbers of (primarily) Sisters, (but also) brothers and priests, willing and able to oversee a complex, highly corporate health care ministry; and (2) substantial, continuing reductions in health care reimbursement, challenging institutional ability to focus on those unable to pay for services.

Either one of these challenges would have been enough to cause reaction within the ministry. Together, these environmental forces have created a whirlwind of change, resulting in a consolidation of Catholic health care providers unparalleled in the history of the ministry. They have forced religious communities and their sponsored works to revisit the genesis of their role in ministry, causing some congregations to withdraw from health care, or to affiliate with others—Catholic and other than Catholic—more capable of assuring financial and/or mission continuity. In still other cases, the desire or need to collaborate has overcome strong historical barriers to cooperation, causing the creation of vast “cosponsored” ministries, some with national reach. The lessons which Catholic health care sponsors and their institutions have learned, and are continuing to learn, offer useful insights to other Catholic ministries, such as education and social service, which are facing similar environmental pressures.

In this article I will explore the concept of sponsorship as a means by which religious communities insure that the mission for which they founded institutions continues to exert its force and realize its goals. I will first explain the concept of “sponsorship” as that term has evolved in Catholic health care. Through this review and discussion, the *structural* aspects of sponsorship will be explored. Next, I will explore the *relational* components of sponsorship, arguing that maintaining critical points of influence is instrumental—perhaps more so than structure—to assuring fidelity to the Catholic health-care mission. Of course, it is the future inability of many religious communities to continue staffing these influence points that is causing the health care ministry to explore new, “next generation” sponsorship models which might be used to assure fidelity to mission and Church.

I will also touch upon institutional and system training programs and practices to integrate and inculcate mission within the organization and its employees. In doing so, I will discuss the evolution of mission fulfillment in Catholic health care, which is moving from assuring fidelity to the *sponsor’s* mission toward assuring fidelity to a broader Catholic Church mission.

Finally I shall explain models of sponsorship, including the movement toward co-sponsorship, as well as sponsorship by the laity.

*Sponsorship*¹

The predominant model of mission accountability in Catholic institutional ministry is that of one or more religious communities “sponsoring” the ministry. While “sponsorship” is now a term of common parlance, in fact it is a word lacking in both legal and canonical definition. A related concept in American common law might be trusteeship, in which a party is entrusted with a good for the benefit of another, although the trustee is not the owner of the good. In canon law, the closest analogous concept is the Code of Canon Law’s requirement that the religious community be a good steward over Church property. As discussed below, the concept of sponsorship encompasses a much richer and deeper relationship than either sets of law might describe.

At the same time, however, because the term lacks legal definition, each religious community is free to use the concept, and fulfill its sponsorship responsibilities, in almost any way in which it sees fit. Indeed, the word has come to encompass any number of legal, canonical, and emotional/historical support relationships which have developed between a religious community or a recognized body of lay persons and a ministry. As such, learning that a religious community sponsors a ministry is essentially an invitation to question the depth and breadth of the relationship existing between sponsor and sponsored.

The concept of sponsorship is only about twenty-five years old, itself having come about due to fewer numbers of religious able to serve in the ministry. Indeed, from the founding of the first Catholic hospital by the Sisters of Mercy in 1847 through the Second Vatican Council, a religious community would never have talked about “sponsoring” a health care ministry. Rather, the prevailing model of connection to the Church was one of “presence”: the hospital was Catholic because it was (literally) built by the Sisters, operated by

¹ This discussion draws heavily from Lawrence Singer and Elizabeth Johnson Lantz, “The Coming Millennium: Enduring Issues Confronting Catholic Health Care,” 8 *Annals of H.L.* 299 (1999). See also Lawrence Singer, “Realigning Catholic Health Care: Bridging Legal and Church Control in a Consolidating Market,” 72 *Tulane L.R.* 159 (1997).

the Sisters, administered by the Sisters, and staffed (often wholly) by the Sisters. Often the institution lacked legal or operational existence separate from its founders.

In the aftermath of the Second Vatican Council many religious communities lost significant numbers of members as new avenues of service to the Church were opened. Members who did remain often chose to avoid service in large institutions, while others sought to move away from the traditional ministries of health care and education. The result was that at a time when health care institutions were facing tremendous growth and needed greater presence by religious communities, communities were unable to continue missioning large numbers of Sisters, brothers, or priests to the ministry.²

The development of the concept of "sponsorship" then moved to the forefront as a way to explain the changed relationship that many congregations experienced with their ministries. Under what can be termed "direct" sponsorship, Sisters moved away from the bedside into first executive, and then more typically governance or oversight (corporate member³) positions. While most of these corporations were initially formed with mandates that the board of directors be comprised of a majority of Sisters, almost all have pared down to requirements of one-third Sisters or less. Often no minimum number is stated, and it is quite common to find institutional boards with only one or two Sisters serving.

Most health care ministries have moved to create parent organizations (systems) to oversee the multicorporate ministry, with the institutions as subsidiaries of this parent. While advantageous from a management/governance oversight perspective, this typically causes a further distancing of the religious community from institutional involvement. Energy is now strongly focused at the parent/system level, with religious communities choosing to focus their limited resources at this upper organizational level, where they can have the greatest strategic impact. While many system boards of directors have been able to maintain a proportionately large number of systems on the board, this will likely change over time as religious communities continue to grow smaller in the future.

Structural Aspects of Sponsorship

From a structural perspective, fidelity to mission and Church in a sponsorship relationship is typically assured through the reservation of certain corporate authorities to the religious community leadership team

(the Superior and Council), itself the elected representatives of the congregation. While the actual authorities maintained may vary, there is broad agreement within the health care ministry that at least five "reserved powers" should be maintained: (i) adoption or approval of corporate philosophy, mission, and value statements; (ii) approval of sale, merger, consolidation, lease, or encumbrance (through mortgage or the like) of the sponsored institution; (iii) appointment and removal of the board of directors; (iv) appointment/removal of the President/Chief Executive Officer; and (v) dissolution.

Some communities reserve the right to initiate these actions, while others may authorize the organization's board of directors to participate in the actions prior to approval by the leadership group. Often other reserved powers are maintained, including approval of operating/capital budgets, strategic plans, certain operational policies, and creation of new sponsored works, among other things. Through retention of these powers, religious communities are vested with the legal authority to assure that the ministry operates in keeping with a Catholic mission. At the same time, canonists would interpret reservation of authority as one of the means by which the religious community fulfills its canonical obligation appropriately to steward the work of the Church.

Of course, retention of authority is only part of the equation, for the community must use its authority to both infuse and inculcate mission and values into the organization. For most communities this involves the careful development of policies and protocols to assure that the authority is used to further mission. For example, as mission and values permeate the organization,

² Sisters sponsor well over 90% of institutional health care services, with approximately 5% sponsored by communities of men and the remaining 5% sponsored by dioceses or recognized bodies of lay people. A 1994 study revealed that there are 80,000 fewer Sisters in the United States than there were in 1967, and that only 3% of Sisters are less than forty years of age. For most religious communities at least one half of their membership is retired, with the community median age well into the sixties.

³ Corporate members are analogous to shareholders in a for-profit corporation. They are vested with certain authority in state non-profit corporation laws; this authority may be supplemented by additional powers reserved to the corporate members in the corporation's articles of incorporation or bylaws.

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the ramifications of reserving this power are significant. Clearly, it calls for the development of comprehensive, ongoing mission education and integration efforts at all levels of the organization.

Indeed, most health care institutions now have dedicated mission-effectiveness personnel on the senior management team, trained in mission integration. Many times these individuals are members of the sponsoring religious community, serving to keep alive the link between sponsor and sponsored work. Larger health care systems may have full-time Board chairs, typically a Sister from the sponsoring community, with primary oversight responsibility for this function. In some systems it is also common to find Vice Presidents of Sponsorship, who are responsible for oversight of mission integration at a regional or institutional level. Through these and analogous mechanisms senior management and the board are continually focusing on the cross section of strategic decision and mission.

Similarly, each of the other reserved powers has its own mission implications. Policies surrounding sale, merger, encumbrance, and dissolution assure that organizational assets continue to be focused on a Catholic mission, and foretell the approach to be taken when that mission may no longer be be realizable. Ongoing education about new developments and deeper understandings of bedrock mission principles is also expected to be offered.

The power to appoint board members leads to the creation of criteria used to select members of the board, as well as a process for such selection, all of which loops back to mission. This authority also requires development of an orientation program to assure that board members understand and embrace the sponsor's and institution's (system's) philosophy, mission, and values. A similar process flows from appointment of the President.

In short, through appropriate structuring and use of the sponsorship authority, sponsors can move toward assurance that the mission for which they founded the ministry is maintained and nurtured.

Relational Aspects of Sponsorship

The relational aspects of sponsorship are perhaps even more important to maintenance of the mission focus. The connection of a religious community to the ministry it founded and nurtured is deep. Most communities are closely identified with their ministries, as the ministry is often the most public face of the sponsor. For health care communities, many of the Sisters have been

educated as nurses or other health care professionals prior to assuming administrative or governance responsibilities. Choice of religious communities by novices is often predicated upon the ministries offered by the community. Histories of religious communities are rich with stories of ministry creation and survival. These stories are retold countless times and become an essential part of the fabric comprising the sponsored institutions.

Maintenance of the relationship between sponsor and sponsored is a key component of sponsorship. Sponsorship takes a great deal of time, and much effort is expended to fulfill the sponsorship responsibility. Superior/Council member service on governing boards, the assumption of leadership positions on these boards, participation at significant institutional and system events, the development of employee/governance inservice events, the offering of periodic mission-themed days, discussion/reports at Council meetings and the like are some of the means typically used by sponsors to assure a strong relationship of fealty to the sponsoring religious community and its mission. As discussed above, many religious communities have missioned Sisters to sponsorship as board chairs, vice presidents, and/or mission integration positions, providing an additional linkage to the sponsor.

Sponsors also focus great energy on governance and senior management relationships. Individuals filling these positions are carefully selected for congruence with mission. Organizations such as Loyola University Chicago School of Law's Center for Catholic Health Care and Sponsorship, among others, work closely with sponsors, trustees, and executives on nurturing these relationships. As alternative sponsorship models move to the fore, it is the closeness and trust of the sponsorship relationship that enables sponsors to reposition the ministry for the future. It is the potential distancing of this relationship, however, that creates concerns about the viability of these new sponsorship models.

Next Generation Sponsorship Models

Recognizing the decreasing numbers of Sisters, Brothers, and priests able to be missioned to sponsorship duties, religious communities in the past five years have moved quickly to merge their ministries into "cosponsorships" so as to work together to assure continuation of the ministry. Under these models, religious communities typically merge ministry assets, agreeing to share reserved powers over the joint enterprise. Most of the largest Catholic health care systems in the United

States have adopted a co-sponsorship model, with several systems comprised of upwards of thirteen religious community sponsors.

Co-sponsorship formation often causes the religious community to move away from the congregational leadership team as the locus of reserved power decision-making as there are often simply too many decision makers involved if the membership of the shared enterprise were to be composed of two or more entire leadership teams. Instead, these leadership teams often designate one or more congregational representatives to serve on a "sponsor's council" which is vested with most reserved powers.

Co-sponsorships represent a further distancing of the religious community from its ministry, since sponsorship is now shared with more or more other sponsors. While typically the particular heritage of the sponsored institutions continues to be celebrated, it is now overlaid with the development of a new culture of the shared whole. For most religious communities involved in co-sponsorship, there is a sense that the ministry is now less Franciscan/Mercy/Benedictine/etc. as the culture moves toward that of being more blended, or "just" Catholic. For some this movement away from the unique Catholic mission brought by the founding sponsor is a source of concern, with the worry being that the ministry's historical commitment to mission fulfillment will be lost. For many sponsors, however, the invitation to be intentional about those aspects that cause an identity between ministry and sponsor, and to move toward a greater connection to a Catholic mission as opposed to the sponsor's mission, is warmly embraced as an affirming act for the Church.

Of course, there is a concern that if the transition toward fulfillment of a co-sponsored mission is not handled well, the ministry could lose an important connection to its heritage and mission fulfillment. Since co-sponsorships are a relatively new phenomenon, culture integration is still underway in most organizations. Unanswered is how a religious community which might, in a sense, be a 1/12th sponsor retains its own connection to this new, larger ministry, or whether this connection becomes so weakened that the community begins to feel isolated from its works. The business effectiveness of some of these cosponsorships is also being called into question, as many involve significant amalgamations of large, sophisticated business enterprises. Cosponsorship opens issues such as executive and board composition, headquarters location, name, financial and cultural inte-

gration and the like, often requiring five or more years for the disparate organizations to become completely assimilated into a unique whole.

A few religious communities have moved beyond co-sponsorship and transferred (“alienated”) their ministry to a recognized group of lay persons. These lay sponsorships, or public juridic person models, have attracted widespread interest within the ministry, and may well represent the future of health care sponsorship if they are successful. To date there are two health care systems operating under this status, with at least two other applications pending acceptance by Rome.

In the public juridic person model⁴ a recognized body of lay and/or religious is empowered by the Church to sponsor a ministry. Sponsorship, for example, might be vested with the organization’s board of directors. In a sense, then, the organization might become self-sponsored, with the board assuming not only the traditional fiduciary responsibilities required of board members by law, but also the broader sponsorship responsibilities of mission fulfillment and connection to the Church. In the alternative, a member body comprised of laity (and perhaps some religious) could be created and vested with reserved powers over the organization, similar to the legal framework currently used by most Catholic health care organizations. Still other permutations are likely to be created.

The ability to transition sponsorship to the laity is obviously one of the most attractive features of this model, as fewer religious communities will be able to continue sponsorship in the future. On the other hand, there is great concern about the ability of these models to be self-perpetuating, and many questions remain unanswered. Among the most pressing questions are the following: How will sponsorship become so ingrained that it can be handed off to succeeding generations of lay sponsors? The ability to develop future sponsors was a natural outgrowth of the religious community, but not so for a group of lay individuals. Inasmuch as the religious community had assumed a corporate commitment to replenish the sponsor role, how can the laity be structured to accomplish this task?

Can a governing board assume this responsibility, or should it be vested in a second group of individuals to whom the board would be accountable? And shouldn’t the board and sponsor be working hand in hand on

these issues (as many do now)? The lack of sufficient experience and direction to these issues has caused many religious communities to delay transition to a lay model. Nevertheless, demographics would suggest that many communities will need to gain a level of comfort with these issues as the evolution of significant portions of the health care ministry to the laity seems inevitable.

The Lessons of Twenty-First Century Sponsorship

Religious communities have been wonderfully successful at creating and sustaining an essential social and spiritual resource for many cities, towns and villages in the United States. Through careful nurturing and a strong commitment to mission and values, health care providers have been able to grow and respond to dynamic environmental challenges while maintaining a strong connection to mission and Church. Religious community sponsorship, through its strong reliance on authority, accountability, and relationship has worked.

At the same time, it is clear that the concept of sponsorship will need to evolve toward the laity as many religious communities lessen their involvement in the ministry. Strong educational programs must be developed to teach essential sponsorship and mission skills. A national cadre of dedicated individuals, able to perpetuate sponsorship among the laity, must be nurtured. Catholic universities, in particular, could have an important role to play in this educational process. Similarly, as other institutional ministries—education, social service, etc.—face similar environmental pressures, a coalition approach of diverse providers working together on sponsorship/mission continuity will likely afford the strongest possible chance for Catholic ministries to continue their strong service to public and Church.

⁴ The Code of Canon Law also provides for establishment of private juridic persons to assume ministry sponsorship. This model is seldom used in health care, although it is somewhat prevalent in education. For discussion of this model see Lawrence Singer, “Realigning Catholic Health Care: Bridging Legal and Church Control in a Consolidating Market,” 72 *Tulane L.R.* 159 (1997).